STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445160	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYFIELD REHABILITATION CENTER	200 MAYFIELD DRIVE SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observations, it was determined the facility failed to maintain the corridor doors. The findings included: Observation of the environmental service in the soiled utility hall on 9/26/11 at 7:45 PM, revealed three doors were being held open with pegs. This findings was acknowledged by the administrator and verified by the director of maintenance at the exit conference on 9/26/11.	K 018	1. Pegs were removed from the 3 propped doors in the soiled utility hallway. The pegs were discarded on 9/26/11. The Maintenance Supervisor and the Assistant are responsible for the removal. 2. Maintenance Supervisor and the Assistant audited the building, through walking rounds, for any other non-compliant doors that could be propped. Any doors found non-compliant would be corrected and any propping mechanism removed and/or discarded. This was completed on 9/27/11. Note: No other doors were found to be propped. 3. Maintenance Supervisor and Assistant will make morning walking rounds during the weekday (Monday-Friday) of the entire building. These walking rounds will include monitoring visually for any doors that present propped and non-compliant with Life Safety Code. Process will begin on 9/27/11 and continue on-going.	
K 029	NFPA 101 LIFE SAFETY CODE STANDARD	K 029		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Debbie Bowers
TITLE: Administrator
(X6) DATE: 10/13/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	K 018 Continued		Compliance rounds will also be conducted with the daily (Monday-Friday) rounds completed by the management team. This team consists of: Unit Managers (3), Risk Manager (LPN), Social\ Services (2), Housekeeping Supervisor, Staff Development Coordinator, Medical Records Clerk and Restorative Nurse. The rounds will commence by 11/3/11 and continue on-going. The management team will be responsible for the completion of the rounds and also reporting any discrepancies to the Maintenance Supervisor for follow-up. The Maintenance Supervisor will follow-up and address those discrepancies. 4. Include a monthly report to the quality assurance committee with results of compliance rounds and any trends and/or problems that are with proper door closings. The Maintenance Supervisor is responsible for monitoring of the outcomes of the compliance rounds. The Quality Assurance Committee consists of the following members: Administrator, Director of Nurses, Bookkeeper, Social Services, Risk Manager, Human Resources, Housekeeping Supervisor, Dietary Manager, Medical Director, Maintenance Supervisor and the Activity Director.	11/7/11

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K 029 SS=E	Continued From page 1 One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observations, it was determined the facility failed to maintain the hazardous areas. The findings included: Observation of the kitchen area and the the mechanical room on 9/26/11 at 6:59 PM, revealed the doors were being held open with equipment. These findings were acknowledged by the administrator and verified by the director of maintenance at the exit conference on 9/26/11.	K 029	1.Removed dietary cart that was holding door open. Done: 9/26/11 Remove equipment blocking door in mechanical room on 9/26/11. 2.Dietary Manager and Maintenance Supervisor audited, through walking rounds, to assure no other doors remained propped. Done: 9/26/11 3 Inserviced dietary personnel on 10/12/11 regrding life safety codes in relation to blocking doors. The Dietary and Maintenance Supervisors will be held responsible for monitoring the compliance through walking rounds by the Dietary Manager and the Maintenance Supervisor monitoring the compliance rounds. The Dietary Manger will conduct departmental compliance rounds that will be included with the department managers compliance rounds that are conducted Monday – Friday.	
K 046 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by:	K 046		

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	K 029 Continued		4. Include the reporting of the outcomes of compliance rounds that are completed by the Dietary Manager and management team. Monday- Friday to the monthly Quality Assurance Committee. The Committee consists of : Administrator, Director of Nurses, Bookkeeper, Social Services, Risk Manager, Human Resources, Dietary Manager, Activity Director, Maintenance Supervisor and Medical Director. The Dietary Manager and the Maintenance Supervisor will be responsible for reporting this information to the Committee.	11/7/11

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K 046	Continued From page 2 Based on observations, it was determined the facility failed to maintain the emergency lights. The findings included: Observation of the corridor by the South nurses' station on 9/26/11 at 7:51 PM, revealed the emergency light's was inoperable. This finding was acknowledged by the administrator and verified by the director of maintenance at the exit conference on 9/26/11.	K 046	1. Repaired emergency lighting system to an operable status. Completed 9-27-11 2. Maintenance Supervisor and Assistant assessed all facility emergency lighting for compliance. Note: all found operable. Completed 9-27-11	
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on observations, it was determined the facility failed to train the staff in fire drills. The findings included: Observation during the fire drill on 9/26/11 at 7:52 PM, revealed the staff did not announce code red, the location of the fire, and failed to close the door where the drill accured.	K 050	1. Fire drill procedures provided to employee who failed to implement the fire procedures. Completed 9-26-11 2. Maintenance Supervisor met with staff, on shift, regarding the proper protocol for discovery of a fire and or when approached by a surveyor regarding the potential fire. Completed 9-26-11 3. Maintenance Supervisor conducted additional mock frills, 10-3-11 and 10-4-11 with staff compliant. Small group in services training will be conducted of facility staff regarding discovery a fire and proper fire safety protocol. In services training will be completed for staff by 11-4-11	

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	K 046 CONTINUED		3. The Maintenance department will utilize a monthly preventive maintenance program which will include testing of all emergency lighting. Findings of all preventive maintenance report outcomes will be reported to the corporate regional maintenance director for review. 4. Monthly Quality Assurance meeting will included the preventive maintenance report for the month. Any trends will results in a business action plan which includes problem identification, goals, interventions and completion dates. The Maintenance Supervisor will be responsible for the monitoring through report outcomes, monthly and reporting those finds to the Quality Assurance committee. 11-4-11	

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	K050 CONTINUED		4. Included reporting of all fire drills and in services training for fire safety to the monthly Quality Assurance committee. Report will include dates/times/shifts of fire drills, compliance status, in services training with dates/times. The Maintenances Supervisor is responsible for monitoring this program through the monthly fire frills and outcomes will determine the need of continuing education and additional mock drills. 11-4-11	

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K 050	Continued From page 3 This finding was acknowledged by the administrator and verified by the director of maintenance at the exit conference on 9/26/11.	K 050		
K 052 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observations, it was determined the facility failed to maintain the fire alarm system. The findings included: Observation of the front lobby and the back door of the kitchen on 9/26/11 at 6:55 PM, revealed the fire alarm pull stations were blocked with equipment. These findings were acknowledged by the administrator and verified by the director of maintenance at the exit conference on 9/26/11.	K 052	1. Green plant removed from blocking pull station on front lobby. Dietary cart removed from blocking pull station in the kitchen. Completed 9-26-11 2. Maintenance Supervisor and Assistant conducted facility audit of all pull stations to determine compliance. Completed 9-26-11 3. Include monitoring compliance with pull station access through the Monday – Friday compliance rounds that are conducted by the management team. The team consists of Unit Managers (3), Risk Manager, Social Services (2), Housekeeping Supervisor, Staff Development Coordinator, Medical Records Clerk, and Restorative Nurse. Any negative findings will be reported to the Maintenance	
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating	K 062	1. Contacted International Fire (Sprinkler Consultant) to require immediate inspection visit for sprinkler inspection. Completed 9-27-11	

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	K052 CONTINUED		Supervisor for immediate interventions Begin 11-7-11 In service management team on new compliance round report. Completed 11-4-11 4. Report will be presented to the monthly Quality Assurance committee of monthly outcomes of the weekly (Monday-Friday) compliance rounds conducted by the management team. The team consists of the following members: Administrator Director of Nurses, Bookkeeper, Social Services, Risk Manager, Human Resources, Housekeeping Supervisor, Dietary Manger, Medical Director, Maintenance Director, and Activities Director. The outcomes will be reviewed by the maintenance Supervisor and trends/issues will require an action plan. Reporting and compliance will be the responsibility of the Maintenance Supervisor. Completed 11-3-11	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	K062 CONTINUED		2. Developed tracking log to monitor frequency of visits by maintenance related contract service visits. Completed log 10-21-11. The Maintenance Supervisor is responsible for Auditing all contract service to assure all visits are timely according to contracts, Completed 10-18-11 3. Facility developed a tracking log as a tool to maintain compliance with service contract visits. Completed 10-21-11 The Maintenance Supervisor is responsible for developing and utilizing the log to keep all contract services visits timely per contracts. The receptionist will be responsible to assist the Maintenance supervisor in maintaining accurate documentation to the tracking log. Receptionist will contact contract services 1 week prior to dues date of visit. Receptionist will also document visits and keep Maintenance Supervisor aware of all contract services due each month Completed 10-21-11 with ongoing monthly notification to Maintenance Supervisor of monthly visits.	

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	K062 CONTINUED		4. Tracking log with visit results will be presented to the monthly Quality Assurance meeting. The Maintenance Supervisor will be responsible for monitoring the log and presenting outcomes of visits of each scheduled maintenance contract services visits. Completed 11-4-11	

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K 062	Continued From page 4 condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observations record and records review, it was determined the facility failed to maintain the sprinkler system. The findings included: Record review on 9/26/11 at 8:30 PM, revealed no quarterly inspections were conducted on the sprinkler system. This finding was acknowledged by the administrator and verified by the director of maintenance at the exit conference on 9/26/11.	K 062		
K 064 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to maintain the fire extinguishers. The findings included: Observations of the kitchen and the corridor by the South hall nourishment room on 9/26/11 at	K 064	1. Removed dietary cart that was blocking fire extinguisher in dietary and removed med cart that was blocking fire extinguisher on South hall. Completed 9-26-11 2. Maintenance Supervisor and Assistant audited building for any additional blocking of fire extinguishers. Completed 9-27-11 3. In service facility staff in life safety codes regarding blockage of fire extinguishers. Initial in service 10/18/11, will follow in services by 11-4-11. The staff Development	

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	K 064 Continued		compliance founds conducted by the management team will include monitoring of the access of fie extinguishers. Any non-compliance will be reported to the Maintenance Supervisor for immediate intervention. The Management team consists of Unit Managers (2), Risk Manager, Social Services (2), Housekeeping Supervisor, Staff Development, Medical Records Clerk, and Restorative Nurse. Completed 11-4-11 4. The Maintenance Supervisor will report compliance outcomes to the monthly Quality Assurance Committee members are: Administrator, Director Of Nurses, Bookkeeper, Social Services, Risk Manager, Human Resources, Housekeeping Supervisor, Dietary Manager, Medical Director, Maintenance Supervisor, Activity Director. Any negative outcomes will require an action plan. Completed 11-4-11	11/4/11

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K 064	Continued From page 5 7:00 PM, revealed the fire extinguishers were blocked with equipment. These finding were acknowledged by the administrator and verified by the director of maintenance at the exit conference on 9/26/11.	K 064	Coordinator and the Maintenance Supervisor will be responsible to conduct these in services. The weekly (Monday-Friday)	
K 066 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on observations, it was determined the facility failed to maintain the smoking areas.	K 066	1. Obtained galvanized cans with lids temporarily to be utilized to empty ash trays of ashes. 2. and 3. Ordered self extinguishing step cans to position in smoking areas for the use in discarding the ashes from the ash trays. Order placed 9-30-11, scheduled delivery 10-11-11. Developed new policy to address the proper disposal of cigarette ashes. Completed 10-19-11 In service Maintenance and Housekeeping staff on the policy and protocol for disposal of ashes/butts. Completed 10-21-11 The Maintenance Supervisor will be responsible for in service training. Housekeeping Supervisor will be responsible to monitor housekeepers to assure the protocol for disposal of ashes is followed. This will be accomplished by designated scheduled days for disposal. Housekeeping Supervisor will document on housekeeping compliance reports weekly.	

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K 066	Continued From page 6 The findings included: Observation of the smoking areas on 9/26/11 at 7:15 PM, revealed ther were no metal containers with self- closing devices into which ask trays can be empty. This findings was acknowledged by the administrator and verified by the director of maintenance at the exit conference on 9/26/11.	K 066	Housekeeping Supervisor will be responsible for reporting the outcomes of these reports to the monthly Quality Assurance committee consists of Administrator, Director of Nurses, Bookkeeper, Social Services, Risk Manager, Human Resources, Housekeeping Supervisor, Dietary Manager, Medical Director, Maintenance Supervisor, Activity Director. Completed 11-7-11	
K 070 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8 This STANDARD is not met as evidenced by: Based on observations, it was determined the facility failed to maintain the portable space heaters. The findings included: Observation of the main office on 9/26/11 at 7:30 PM, revealed a portable space heater fan would not shut off when the heater was turn on it's side. This findings was acknowledged by the administrator and verified by the director of maintenance at the exit conference on 9/26/11.	K 070	1. Heater removed form receptionist area, Completed 9-26-11 2. Maintenance Supervisor and Assistant audited all offices for any use of space heaters. None found. Completed 9-27-11 3. In services administrative personnel regarding use of space heaters. Completed 11-2-11 at 9 am. Notify residents and responsible parties, by letter of life safety compliance regarding use of space heaters. Completed 11-7-11 Monitor compliance of use of space heaters through the weekly (Monday-Friday) compliance rounds conducted my the management team. The team consist of Unit Managers (2), Risk Manager, Social Services (2), Housekeeping Supervisor Staff	
K 130 SS=D	NFPA 101 MISCELLANEOUS	K 130		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445160	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYFIELD REHABILITATION CENTER	200 MAYFIELD DRIVE SMYRNA, TN 37167

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	K070 CONTINUED		Development Coordinator, Medical Records Clerk, Restorative Nurse. Completed 11-4-11. Any negative outcomes of the compliance rounds will be submitted to the Maintenance Supervisor to intervention. 4. Include reporting of compliance rounds outcome to the monthly Quality Assurance Committee. The committee consists of Administrator, Director of Nurses, Bookkeeper, Social Services, Risk Manager, Human Resources, Housekeeping Supervisor, Dietary Manager, Medical Director, Maintenance Supervisor, and Activity Director. Completed 11-4-11 11-7-11	

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	445160	A. BUILDING 01 - MAIN BUILDING 01 B. WING	09/26/2011

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K 130	Continued From page 7 OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Compressed or liquefied gas cylinders in use or in storage shall be secured to prevent them from falling or being knocked over. Based on observations, it was determined the facility failed to maintain the oxygen cylinders. The findings included: Observation of the physical therapy area on 9/26/11 at 7:35 PM, revealed 2 cylinders of oxygen were not secured. This finding was acknowledged by the administrator and verified by the director of maintenance at the exit conference on 9/26/121.	K 130	1. Removed oxygen cylinder form physical therapy area and placed in oxygen storage rack. Completed 9-26-11 Informed Rehabilitation Director of deficient practice. Completed 9-26-11 2. Maintenance Supervisor and Assistant audited oxygen cylinders to assure proper storage. Completed 9-26-11 3. Weekly (Monday – Friday) compliance rounds include monitoring of proper storage of oxygen cylinders. Rounds conducted by management team. Team consist of Unit Manger (3) , Risk Manager, Social Services, Housekeeping Supervisor, Staff Development Coordinator, Medical Records Clerk, Restorative Nurse	
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observations, it was determined the facility failed to maintain the electrical system. The findings included: (1) Observations of the soiled utility room and the central supply closets on 9/26/11 at 7:40 PM, revealed the electrical panels were blocked with	K 147		

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	445160	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	K130 CONTINUED		Any non-compliance will be reported to the Maintenance Supervisor for intervention. Completed 11-4-11 4. Include the outcomes of the compliance rounds which include the storage of oxygen cylinders. Negative outcomes require an action plan. The Maintenance Supervisor will be responsible for reporting to the Quality Assurance Committee. The committee consists of the following members: Administrator, Director O Nurses, Bookkeeper, Social Services, Risk Manager, Human Resources, Housekeeping Supervisor, Dietary Manager, Medical Director, Maintenance Supervisor, and Activity Director.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAI ERVICES

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	445160	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/26/2011

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K 147	Continued From page 8 equipment. (2) Observation the central supply mechanical room on 9/26/11 at 7:50 PM. revealed a broken light cover. These findings were acknowledged by the administrator and verified by the director of maintenance at the exit conference on 9/26/11.	K 147	1. Moved all equipment from soiled utility room and central supply closet leaving clear access to electrical panels, "DO NOT BLOCK". Completed 9-27-11 Light cover replaced in central supply mechanical room. Completed 9-27-11 2. Maintenance Supervisor and Assistant audited building for compliance of access for electrical panels. Completed 9-27-11 Maintenance Supervisor and Assistant audited building to assure all light covers are in place. Completed 9-27-11 3. Include in daily (Monday-Friday) compliance rounds, conducted by management team, the accessibility of electrical panels and compliance with light covers. The team consist of Unit Manager (3), Risk Manager, Social Services (2), Housekeeping Supervisor, Staff Development Coordinator, Medical Records Clerk, Restorative Nurse. Any non-compliance of rounds will be reported to the Maintenance Supervisor. Completed 11-4-11	

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			4. The Maintenance Supervisor will be responsible for bringing the outcomes of the compliance rounds to the monthly Quality Assurance Committee. Any negative outcomes will require an action plan which will be included in the monthly Quality Assurance agenda until it is resolved.	11/4/11